Therapeutic Services

DIDD Required Policy List and SAMPLE TEMPLATES

September 2014

Required DIDD Policies Listing and Sample Templates
Effective March 15, 2014

Providers are required to prepare a DIDD policy manual. This manual shall be in place prior to initiating services once approved as a provider. For providers of occupational therapy, physical therapy, speech language pathology, and nursing the required DIDD policies are ***in addition to*** policies required for the Professional Support Services (PSS) license.

The following grid outlines the required DIDD policies (bolded), and indicates where there is also a requirement for a Professional Support Services License policy. When required by both departments, the policy can be combined as long as it meets all applicable requirements.

Details regarding required DIDD policies are located in the DIDD Provider Manual as indicated. Sample policy templates are included in this packet.

Provider Manual Chapter 13, 13.2.f.1.a Background checks	
Provider Manual Chapter 13, 13.2.f.1.b. Initiating and employing disciplinary actions	
Provider Manual Chapter 13, 13.2.f.1.c. Drug free workplace requirements	
Provider Manual Chapter 13, 13.2.f.1.b (page 13-5) Personnel records Job descriptions, credentials, and verification of references Ensuring a well-trained workforce Tuberculosis testing Performance evaluations	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.2. Showing respect to persons supported	
Provider Manual Chapter 13, 13.2.f.3. Serving as an advocate for persons supported and referring to external advocacy	
Provider Manual Chapter 13, 13.2.f.4. Taking appropriate actions in emergency situations	
Provider Manual, Chapter 13, 13.2.f.5. Managing and reporting incidents using DIDD procedures	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.6. Maintaining Title VI compliance	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.7. Protection and promotion of people's rights	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.8. Protection from and prevention of harm	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.9. Complaint resolution	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.10. Assuring staff coverage for services and adhering to service schedules	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.11. Supervision plan (as applicable when using therapy assistants)	Also required for PSSL
Provider Manual Chapter 10, Section 10.8c Maintenance and confidentiality of medical records	Also required for PSSL
Provider Manual Chapter 13, Section13.7 Self-assessment and Internal Quality Improvement	Also required for PSSL
Provider Manual Chapter 13, 13.2.f.4. (Page 13-6) Transportation (if applicable)	

AGENCY NAME

CRIMINAL BACKGROUND CHECKS
AND
REFERENCE CHECKS

Provider Manual-Chapter 13, 13.2.f.1.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ completes background checks for each staff member and/or contracted staff in accordance with DIDD requirements.

B. Objectives

To assure that statewide and/or national criminal background checks are performed for each staff and/or contracted staff member having direct contact with or direct responsibility for persons receiving services.

C. Procedures

1. The applicant will be told that a criminal background check will be conduced;
2. Prior to assignment or change of responsibilities involving direct contact with persons receiving services, certain information must be obtained from the applicant;
3. Required information must be submitted to the entity conducing the criminal background check;
4. Background checks must include:
    a. A criminal background check including either fingerprint samples for a criminal history background check conducted by the Tennessee bureau of Investigations (TBI) or the Federal Bureau of Investigations (FBI) or information necessary for a criminal background check to be conducted by a Tennessee-licensed private investigation company.
    b. For an individual who has lived in Tennessee for one year of less, a nationwide background check is required. Such nationwide background checks may be limited to those states in which the person has lived for the past seven years or since the age of eighteen, whichever is less.
    c. Tennessee Abuse Registry search.
    d. Tennessee Sexual Offender Registry searcb.
    e. Search of the Office of Inspector General (OIG) List of Excluded Individuals/Entities.
    f. Tennessee Felony Offender Information Lookup (FOIL) search.
5. For independent practitioners, background checks are done during the application process and are kept on file at the DIDD Central Office.
6. Ongoing OIG screenings will be conducted monthly in accordance with requirements set forth in the DIDD Provider Manual Chapter 5, Section 5.2.g.3 and the agency's Provider Agreement.
7. Documentation gathered from the background check activities will be filed in the individual's personnel record.

Policy Implementation Date:

AGENCY NAME

Consent for Pre-Employment Reference and Background Checks

I recognize that any offer of employment to me by _____ is conditional upon my successfully passing reference and background screenings. I understand that _____ shall conduct Pre-Employment Reference and Background Checks thoroughly and within the confines of all applicable state and federal laws.

In consideration of _____ review of my application for employment, I hereby release any individual, entity, and _____ from all claims or liabilities that might arise from the inquiry into or disclosure of such information, including claims under any federal, state, or local civil rights law and any claims for defamation or invasion of privacy.

I hereby voluntarily consent to and authorize_____, or its authorized representative bearing this release or copy thereof, in connection with my application for employment with _____, to obtain a consumer report (no credit check will be performed) for employment purposes including:

Criminal History
Department of Motor Vehicle History
Certification and Licensing
Educational Credentials
Employment Eligibility (Social Security Number Check)
Employment Checks
Reference Checks

I authorize all persons who may have information relevant to this research to disclose such information to _____, or its agents, and I hereby release all persons from liability on account of true and accurate disclosure. I hereby further authorize that a photocopy of this authorization be considered as valid as the original. Should there be any questions as to the validity of this release, you may contact me as indicated below.

_____
Signature of Applicant Date

_____
Printed Name (First, Middle, Last, Maiden)

_____
License Number, State

_____ - _____ - _____ _____
Social Security Number Telephone Number

_____
Address (Street, City, State, Zip)

If any additional information relative to change of name or use of an assumed name or nickname is necessary to enable a check on your background, please explain below.

_____

AGENCY NAME

EMPLOYEE DISCIPLINARY ACTION
AND
PLACEMENT ON THE TENNESSEE'S DEPARTMENT OF HEALTH ABUSE REGISTRY

Provider Manual-Chapters 7, 7.4 and 13, 13.2.f.1.b.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

Agency will have a system to initiating/employing progressive employee disciplinary actions

B. Objective

Progressive discipline is a process for dealing with job-related behavior that does not meet expected and communicated performance standards. The primary purpose for progressive discipline is to assist the employee to understand that a performance problem or opportunity for improvement exists.

C. Procedures

a. Oral warning
    i. Identify the performance issue for the employee.
    ii. Explain to the employee how the performance issue is affecting his/her performance.
    iii. Ascertain the employee's understanding of the agency requirements.
    iv. Determine factors that are contributing to the performance issue.
    v. Determine steps to be taken to resolve the performance issue and set applicable timelines.
    vi. Files notes regarding the oral warning in the employee's personnel record.

b. Written warning
    i. Provide a written warning to the employee regarding the performance issue outlining steps to be taken in the event that performance does not improve based on specific timelines.
    ii. File the written warning in the employee's personnel record.
    iii. Meet with the employee, if applicable, to discuss details.

c. Suspension
    i. Provide written notification of suspension to the employee with details regarding the performance issue and unmet steps to resolve.
    ii. File the written suspension notification in the employee's personnel record.

d. Termination
    i. End the employment of an individual who refuses to resolve performance issues.

e. Depending on the event/performance issue, the above steps may be modified or certain steps may be skipped.

f. In certain serious circumstances (i.e. verbal/physical altercations with other employees) immediate termination can occur.

g. Investigations:
    i. Staff involved in an investigation of potential abuse and/or neglect of a service recipient will be temporarily suspended from direct contact with persons receiving services while the investigation is conducted.
    ii. If a written request for an exception to the requirement for the staff to be placed on administrative leave or reassigned from direct contact with persons receiving services is submitted to the DIDD Director of Investigations, the staff will be placed on leave or reassigned from direct services pending approval or denial of the request.
    iii. Any staff substantiated for abuse or neglect of a level that results in them being placed on the TN Abuse registry will result in immediate termination.

Policy Implementation Date:

AGENCY NAME

DRUG FREE WORKPLACE

Provider Manual-Chapter 13, 13.2.f.1.c.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will promote a drug-free workplace.

B. Objective

_____ is committed to providing a safe work environment and to fostering the well-being and health of its employees/contractors. A drug free workplace promotes high levels of productivity, safety of clinicians and people receiving services, reduces agency costs, risks and absenteeism. Therefore, the DIDD Middle TN Assistive Technology Clinic DIDD has established the following policy pursuant to Tennessee Code Annotated 50-9-100 et. seq.

C. Procedures

1. It is a violation for any employee or contracted employee to:
    i. Use, possess, sell, trade, offer for sale, or offer to buy illegal drugs or otherwise engage in the illegal use of drugs on or off the job.
    ii. To work under the influence of or while possessing in his or her body, blood or urine, illegal drugs in any detectable amount.
    iii. Report to work under the influence of or impaired by alcohol.
    iv. Use prescription drugs illegally, i.e. to use prescription drugs that have not been legally obtained or in a manner or for a purpose other than as prescribed. However, nothing in this policy precludes the appropriate use of legally prescribed medications
2. Violations of this policy are subject to disciplinary action up to and including termination.
3. If a supervisor sees changes in an employee or contracted employee's behavior that suggests that an employee may have a drug problem, her or she will discuss the behaviors with the employee, provide available resources, and encourage the employee to seek help.
4. The confidentiality of any information received by the employer through a substance abuse testing shall be maintained, except as otherwise provided by law.
5. Upon employment, all employees must consent to submit to drug testing under the following circumstances:
    i. When there is reasonable suspicion to believe that an employee is illegally using drugs or abusing alcohol. .'Reasonable suspicion' is based on a belief that an employee is using or has used drugs or alcohol in violation of the employer's policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon, but not limited to, the following:
        1. Observable phenomena while at work such as direct observation of substance abuse or of the physical symptoms or manifestations of being impaired due to substance abuse;

2. Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance;
3. A report of substance abuse provided by a reliable and credible source;
4. Evidence that an individual has tampered with any substance abuse test during his or her employment with the current employer;
5. Information that an employee has caused or contributed to an accident while at work; or
6. Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the employer's premises or while operating the employer's vehicle, machinery, or equipment.
7. When employees have caused or contributed to an on-the-job injury that resulted in a loss of work-time, which means any period of time during which an employee stops performing the normal duties of employment and leaves the place of employment to seek care from a licensed medical provider. An employer may send employees for a substance abuse test if they are involved in on-the-job accidents where personal injury or damage to company property occurs.
8. As part of a follow-up program to treatment for drug abuse.
9. Routine fitness-for-duty drug or alcohol testing. A covered employer must require an employee to submit to a drug or alcohol test if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination where the examinations are required by; law, regulation, are part of the covered employer's established policy, or one that is scheduled routinely for all members of an employment classification group.

6. If a supervisor determines that an employee reporting to work appears visibly impaired, he or she will deem the employee unable to perform required duties and not allowed to work. If possible, the supervisor may seek a second opinion from another supervisor or office manager when making this determination.
7. The supervisor will implement agency drug testing procedures as appropriate. The supervisor will arrange safe transportation, accompanying the employee as needed, so that drug testing can be performed.
8. Failure of an employee to submit to a required substance abuse test also is misconduct and shall be subject to discipline up to and including termination.
9. Following drug testing, the testing entity shall provide the employee with a listing of common medications and substances which may alter or affect the outcomes of a drug or alcohol test. This form will have a space for the employee to provide any information that he/she considers relevant to the test including the identification of currently or recently used prescription or non-prescription medication, etc.

Policy Implementation Date:

Agency Name

Active Employee Certificate of Agreement

This certificate becomes part of the active employee's personnel file.

I do hereby certify that I have received and read the DIDD substance abuse and testing policy and have had the drug-free workplace program explained to me. I understand that if my performance indicates it is necessary, or if I am the subject of a random drug test, I will submit to a drug and/or alcohol test. I also understand that failure to comply with a drug and/or alcohol testing request or a positive confirmed result for the illegal use of drugs and/or alcohol may lead to discipline up to and including termination of employment and/or loss of workers' compensation benefits.*

* (pursuant to T.C.A. Section 50-9-100 et. seq.)

_____

Name of Employee (please print)

_____

Employee's Signature

_____

Date

AGENCY NAME

PERSONNEL RECORDS

Provider Manual-Chapter 13, 13.2.F.2. (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy:
_____ will maintain confidential personnel records that are subject to review during Department of Intellectual and Developmental Disabilities surveys.

B. Objective:
To identify the documents to be maintained in the personnel records.

C. Procedure:
1. Personnel records shall be kept on all employees and contracted staff for the agency.
2. Personnel records shall be maintained in a confidential manner and overseen by the agency administrator.
3. Personnel records shall include at a minimum:
    - Application
    - Resume
    - Reference Checks
    - Current professional license
    - Verification of licensure
    - Background check results
    - Monthly Office of Inspector General search reports
    - Signed confidentiality agreement
    - Documentation of required orientation and training
    - Required ongoing continuing education
    - Performance evaluations
    - Copy of subcontract agreement (if applicable)
    - Any disciplinary actions
    - Perpetrator history (substantiated abuse, neglect or exploitation allegations)
    - Consent forms signed by the employee to allow completion of background checks or access other employment related information
    - Job description
    - Proof of adequate medical screening to include a TB skin test (if applicable), and HIV and Hepatitis screening upon exposure
    - A copy of contracts with contracted staff.
4. Personnel shall have access to their file when requested.

Policy Implementation Date:

SAMPLE ***AGENCY NAME***

JOB DESCRIPTION
SPEECH-LANGUAGE PATHOLOGIST

POSITION SUMMARY:
The Speech-Language Pathologist provides professional support services which may include evaluation and treatment of persons receiving services with speech, language, hearing, oral motor or swallowing disorders.

ORGANIZATIONAL STRUCTURE:
The Speech-Language Pathologist is accountable to the Administrator or supervising designee.

RESPONSIBILITIES:

1. Completes the initial evaluation and admission for persons receiving services admitted for speech therapy services and develops plan of care.
2. Provides treatment for persons receiving services to relieve speech, language, hearing, and oral motor or swallowing disorders.
3. Instructs the persons receiving services and their caregivers when applicable in the care and proper use of equipment and devices. Also advises and consults with the physician regarding the feasibility of equipment and devices.
4. Instructs other planning team personnel, family, and/or caregivers in assisting with the implementation of the Plan of Care/Individual Support Plan when applicable.
5. Schedules and conducts treatments and consultation according to service recipient's needs (as able) and the physician's orders.
6. Documents appropriate progress and clinical notes indicating service recipient's response to therapy.
7. Evaluates the persons receiving services' progress monthly and submits a monthly progress report.
8. Coordinates discharge planning as appropriate.
9. Confers with other disciplines as needed.
10. Documents time, data and daily visits per company policy.
11. Completes and submits required documentation in a timely manner.
12. Maintains a positive relationship with persons receiving services, support staff, physicians, other Planning Team members, and co-workers.
13. Maintains established agency policies and procedures, objectives, safety, environmental, and infection control policies.
14. Maintains and protects service recipient's confidentiality.
15. Participates in required training activities.
16. Performs other duties as assigned.
17. Maintains required continuing education units to satisfy licensure needs.

POSITION QUALIFICATIONS:

- Educational Requirements: Master's level degree in Speech –Language Pathology
- Current Tennessee licensure as a Speech Pathologist
- Valid driver's license

_____ _____
Signature Date Reviewed

Date Developed:

AGENCY NAME

ENSURING A WELL-TRAINED WORKFORCE

Provider Manual-Chapters 6 and 13, 13.2.f.1.c. (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

An ongoing educational program shall be planned and conducted to develop and improve skills of all personnel engaged in the delivery of professional support services in order to maintain a well-trained work force.

B. Objectives

1. To ensure adequate orientation of new staff to the agency and the interrelated systems, policies and procedures, and the employees job responsibilities.
2. To support staff in developing the skills necessary to work within the field of intellectual and developmental disabilities, increasing their level of competence, and increasing their productivity.
3. To meet the required training standards set forth by the Department of Intellectual and Developmental Disabilities (DIDD).
4. To maintain a well- trained work force.

C. Procedures

1. Each new staff member will be formally oriented to the agency and its related systems (DIDD). This orientation will be documented and filed in the staff's personnel record.
2. The agency will assure that required DIDD orientation and training is scheduled and completed within specified time frames.
3. Documentation of all training and/or continuing education will be completed and filed in the staff member's personnel record.
4. Persons providing services will be encouraged to cultivate their job by taking advantage of training and continuing education courses through DIDD, professional associations and agencies, university classes, and other related resources that demonstrate both the supervisor's and staff member's commitment to continuous skill development.

Policy Implementation Date:

AGENCY NAME

TUBERCULOSIS TESTING

Provider Manual-Chapter 13, 13.2.f.1.D. (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

Agency will follow the Department of Health (DOH) recommendations for tuberculosis testing.

B. Objective

To reduce the risk of exposing persons receiving services or others on the job to tuberculosis.

C. Procedures

a. Agency will determine upon hiring the risk level of each employee/contract staff in regards to having had exposure to tuberculosis (TB).

(Note: Based on the above current CDC recommendations, the Tennessee Department of Health has instituted a policy that targeted tuberculin testing of high-risk persons be performed statewide, and that tuberculin testing of low-risk groups be discouraged.)

b. In accordance with the DOH TB policy, TB testing should only be performed for the following persons at higher risk for exposure to or infections with TB:
   i. Close contacts of a person known or suspected to have TB
   ii. Foreign-born persons from areas where TB is common
   iii. Health care workers who serve high-risk clients
   iv. Mycobacterium laboratory workers
   v. Persons with HIV infections or AIDS
   vi. Persons with medical conditions that place them at high-risk
   vii. Person who inject illegal drugs
   viii. Residents and staff or volunteer workers in high-risk congregate settings (alcohol and drug rehabilitation or methadone maintenance centers, homeless shelters, correctional facilities, mental health facilities, and long-term care facilities)
   ix. Children under 18 years of age exposed to adults in high risk categories
   x. Homeless persons
   xi. Residence or prolonged travel in a country where TB is common
   xii. Other high-risk populations as locally defined by the Department of Health
c. If staff meet any of the above criteria, they will be asked to pursue a TB screening at their local health clinic. Results will be filed in their personnel file.

Policy Implementation Date:

AGENCY NAME

PERFORMANCE EVALUATION

Provider Manual-Chapter 13, 13.2.f.1.e. (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

A formal written performance evaluation will be conducted annually on all staff members.

B. Objectives

1. To ensure that an employee understands the responsibilities of his or her position.
2. To ensure that an employee can satisfactorily fulfill the demands of the position.
3. To facilitate communication between the employee and their supervisor in an effort to promote more effective job performance.
4. To identify performance problems.
5. To improve the performance of an employee.

C. Procedure

1. The Performance Plan and Review process is a three-step process that requires active participation of both the supervisor and the staff member including:
    - Establishment of mutually agreed upon goals and objectives;
    - Interim review of objectives; and
    - Annual performance plan and review.
2. The administrator is responsible for maintaining or delegating to supervisors the responsibility of maintaining a schedule for the Performance Plan and Review process for each staff member.
3. During orientation to the agency, each staff member shall receive appropriate orientation to the agency, including the staff's job responsibilities as outlined in the job description and completion of DIDD required training within required timelines. Documentation of this orientation must be signed and filed in the personnel record.
4. At the onset of employment, the supervisor will schedule a time to produce a performance plan together with the new employee.
5. The performance-planning meeting shall be documented indicating the attendance of the staff and supervisor. This documentation as well as a formal performance plan will be signed and dated by both the supervisor and the staff member and filed in the personnel record.
6. The following steps are to be taken in order to complete the Performance Plan and the Review process:
    - Performance plan (measurable annual goals and objectives) developed based on job responsibilities.
    - Establish priority of duties
    - Identify the standards upon which performance will be measured for each of the duties identified
    - Interim reviews (a minimum of two per year will be held between the supervisor and staff with more frequency as indicated if problems arise) to discuss progress of goals and objectives and for the supervisor to note any problems and develop a plan of action for improvement (also a time for staff to indicate needs for more support in particular areas)
    - An interim performance review will be conducted to ensure that employees do not continue to provide direct services or have direct responsibility for persons

receiving services upon receipt of information indicating that an employee is convicted of criminal activity during employment (e.g., fraud, misappropriation of funds, breach of fiduciary duty) or if an employee is placed on the Department of Health's Tennessee Abuse Registry.

- Annual performance and review

7. Once the Performance Plan and Review process has been completed, the documents will be signed by both the supervisor and staff member to indicate that it has fully been fully discussed (the staff member's signature does not indicate agreement with the evaluation, only that the formal discussion has taken place). The staff member will have the opportunity to make comments in response to the performance review on the document itself or as an attached document.
8. A final signed copy of the performance evaluation will be kept on file in the personnel record.

Policy Implementation Date:

AGENCY NAME

SHOWING RESPECT TO PERSONS SUPPORTED

Provider Manual-Chapter 13, 13.2.f.2.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will show respect to persons receiving services during service delivery.

B. Objective

1. To show respect for persons receiving services during service delivery.

C. Procedure

1. _____will show respect to persons receiving services by:
   - Scheduling appointments in advance;
   - Maintaining the schedule or contacting the service recipient as soon as the need to reschedule is recognized;
   - Speaking directly with the service recipient;
   - Calling the service recipient by name;
   - Considering the service recipient's preferences;
   - Focusing on the needs and goals of the service recipient;
   - Explaining to the service recipient what is occurring during services to provide advanced notice so that the service recipient is informed;
   - Considering the perspective of the service recipient during all services provided;
   - Providing privacy as necessary during appointments.

Policy Implementation Date:

AGENCY NAME

SERVING AS AN ADVOCATE

Provider Manual-Chapter 13,13.2.f.3.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will serve as an advocate for the service recipient and refer to external advocacy services as needed.

B. Objectives

1. To serve as an advocate for the service recipient.
2. To provide referrals to external advocacy to persons receiving services as needed.

C. Procedure

1. Staff will advocate for persons receiving services.
2. Staff will participate in the appeals process to advocate for persons receiving services who receive an Adverse Action in regards to applicable services.
3. Staff will provide the needed information during the appeal according to the timeframe requirements.
4. Staff will assist the service recipient in contacting the DIDD Office of the Director of Appeals to clarify questions or concerns they have regarding the appeal process.

Policy Implementation Date:

AGENCY NAME

TAKING APPROPRIATE ACTION IN EMERGENCY SITUATIONS

Provider Manual - Chapter 13, 13.2.f.4.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ staff take appropriate action in emergency situations

B. Objectives

5. To ensure that appropriate actions are taken during emergency situations.

C. Procedures

1. Staff will respond within the scope of practice during emergency situations to minimize negative effects to the persons receiving services.
2. Staff will make themselves aware of emergency exits both in the homes of individuals and in agencies in which services are provided.
3. Staff will follow directions from agency staff for emergency situations when providing services in homes/other agencies.
4. Staff will assist in evacuating persons receiving services as directed in emergency situations.
5. Staff will remain with persons receiving services as necessary during emergency situations to ensure that they are safe or until other appropriate help arrives to fulfill this role.

Policy Implementation Date:

AGENCY NAME

MANAGING AND REPORTING INCIDENTS USING DIDD PROCEDURES

Provider Manual-Chapter 13, 13.2.f.5.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will report DIDD defined Reportable Incidents and allegations of abuse or neglect with appropriate and timely responses and will ensure immediate response to the health and safety risks of persons receiving services, staff, and others associated with each reportable incident or allegation.

B. Objectives

2. To assure the protection and safety of persons receiving services.
3. To address issues promptly and appropriately.
4. To minimize the future risk of similar incidents or events.
5. To provide appropriate and timely response to Reportable Incidents, including but not limited to all incidents leading to serious harm or a significant risk of serious harm and all allegations of abuse, neglect or exploitation of persons receiving services.

C. Procedure

a. _____ must comply with DIDD requirements in Incident Reporting by taking actions that may include but are not limited to:
   i. Obtaining needed medical attention for persons receiving services, staff or others who are injured or harmed;
   ii. Immediately correcting any physical hazard that may have contributed to the incident;
   iii. Immediately reporting staff conduct that may have contributed to the incident;
   iv. Notifying the service recipient's support coordinator/case manger of the incident, including the need to obtain approval for additional services or supports or the need for funding to complete physical plant or adaptive equipment repairs, adoptions or replacement as warranted and;
   v. Consulting with the support coordinator/case manager regarding initiating planning to arrange for any counseling or psychiatric care that may be needed by the service recipient due to the trauma of being the victim of an incident.

b. _____ will provide immediate (as soon as possible or within 4 hours) notification via the DIDD Investigation Hotline for all reports of alleged or suspected abuse, neglect, exploitation and serious injury of unknown cause, as well as service recipient deaths that are questionable or suspicious, potentially involving abuse or neglect.

c. _____ must comply with DIDD requirements in Incident Reporting by the eight basic areas listed below:
   i. By providing immediate response to the safety and/or health risks associated with each Reportable Incident;
   ii. Incidents that are defined as Reportable Incidents that must be reported to the DIDD Central Office;
   iii. Reportable Incidents that must be reported immediately (as soon as possible but within 4 hours) must be reported to the DIDD Investigation Hotline;
   iv. Timely review or weekly review, follow up and closure of Reportable Incidents;

v. Requirements for notification of entities external to the provider organization and DIDD of the occurrence of Reportable Incidents and the DIDD investigative findings and recommendations
vi. Timely response to findings associated with Reportable Incidents and DIDD investigations and allegations of abuse, neglect, exploitation and serious injuries of unknown origin;
vii. Trend studies of reportable incidents and substantiated reports of abuse, neglect and exploitation; and
viii. Risk assessments/reviews of persons receiving services, community homes/programs or other situations/circumstances which trend studies identify as presenting high protection and safety risks.

d. DIDD defined events and incidents must be documented on the DIDD Reportable Incident Form.
e. In addition to the Reportable Incident Form to the DIDD Central Office, the Administrator on Duty (AOD) will be contacted by AOD pager in the event of:
   i. A service recipient death
   ii. A reportable medical incident resulting culminating in an unplanned hospitalization or;
   iii. A behavioral or psychiatric, missing person, sexual aggression or criminal conduct incidents when law enforcement or a Mental Health Crisis Team is involved in the scene or if the incident results in hospitalization.
f. The Regional AOD crisis pager may be utilized to obtain emergency approval of services when DIDD Regional Offices are closed. 615-282-4364
g. The front page of the DIDD Reportable Incident form will be submitted to the DIDD Central Office and ISC via secure fax or secure email within one (1) working day of the time the incident occurred or was discovered.
h. In the event two or more provider agencies witness a reportable incident, the primary service provider has the obligation to report. When _____ is the "other" agency, _____ will obtain written confirmation that primary provider filed the report.

Policy Implementation Date:

Please contact your Regional Incident Management Director for the most current copy of the

REPORTABLE INCIDENT MANAGEMENT REPORT

for inclusion in your POLICIES AND PROCEDURES MANUAL.

AGENCY NAME

MAINTAINING TITLE VI COMPLIANCE

Provider Manual - Chapter 13, 13.2.f.6.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will maintain Title VI compliance.

B. Objective

_____ ensures that persons receiving services receive equal treatment, equal access, equal rights, and equal opportunities without regard to race, color, national origin, or Limited English Proficiency (LEP).
_____ will not exclude, deny benefits to or otherwise discriminate against any service recipient based on race, color or national origin.

C. General Procedures:

1. _____ will designate a Title VI Local Coordinator.
2. The Title VI Local Coordinator is _____ until further notice.
3. _____ will provide Title VI information to all persons receiving services face to face or by mail prior to the initiation of an initial assessment informing them who the Title VI coordinator is and how to contact in the event that they have a complaint.
4. In the event of a complaint, the Title VI Coordinator will assist the complainant in accessing the DIDD Title VI Grievance Procedures and grievance form either by accessing the DIDD website or providing the form directly to the complainant.
5. All staff will complete DIDD approved Title VI training within 60 days of employment/contracting and complete the annual refresher training thereafter to address the following:
    a. Training to ensure Title VI compliance during service provision;
    b. Training to ensure recognition of and appropriate response to Title VI violations; and,
    c. Training regarding complaint procedures and appeal rights pertaining to alleged Title VI violations for persons receiving services.
    d. Training regarding personnel practices governing response to employees who do not maintain Title VI compliance in interacting with persons receiving services.
6. Staff failure to maintain Title VI compliance in interacting with persons receiving services will be required to participate in a remedial action to be determined based on the findings following the investigation of the complaint.
7. _____ will complete and submit an annual Title VI self-survey in the format designated by DIDD.
8. The _____ Local Title VI coordinator will maintain documentation pertaining to individual Title VI complaints for a minimum of three (3) years and will forward documents to the DIDD Regional Office Title VI coordinator per DIDD requirements.

DISCRIMINATION IS PROHIBITED

Policy Implementation Date:

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION, DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

Prohibited Practices Include:

- Denying any individual any services, opportunity, or other benefit for which he or she is otherwise qualified;
- Providing any individual with any service or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
- Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
- Restricting any individual in any way in the enjoyment of services; facilities; or any other advantage, privilege, or benefit provided to others under the program;
- Adopting methods of administration that would limit participation by any group of recipients or subject them to discrimination;
- Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
- Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and a disproportionate burden of environmental health risks on minority communities.

Should you feel you have been discriminated against, please contact the local Title VI coordinator

Name: _____ Title: _____

Address: _____

Phone Number: _____ Fax: _____

- **Any individual may file a Title VI complaint with the below listed entities.**
  It is preferable that complaints be registered at the local level first.

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES TITLE VI COMPLIANCE DIRECTOR
BRENDA D. CLARK
500 DEADERICK STREET NORTH
ANDREW JACKSON BUILDING, 15TH FLOOR
NASHVILLE, TN 37243
(615)253-6811 OR 1-800-535-9725

OR

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE
REGIONAL MANAGER, OFFICE FOR CIVIL RIGHTS – REGION IV
ATLANTA FEDERAL CENTER, SUITE 3B70
61 FORSYTH STREET, S.W.
ATLANTA, GA 30303
(404) 562-7886

_____ _____ _____ _____

Service Recipient or Legal Representative **Date** **Service Provider** **Agency Representative** **Date**

AGENCY NAME

PROTECTION AND PROMOTION OF PEOPLE'S RIGHTS

Provider Manual Chapters 2 and 13, 13.2.f.7.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will ensure that staff protect the rights of persons receiving services.

B. Objective

To ensure that persons receiving services' rights are protected.

Procedure

1. Staffs follow the values listed in Title 33 as the basis for service delivery to people with mental retardation including:
    a. Individual Rights
    b. Promote Self-Determination
    c. Optimal health and safety
    d. Inclusion in the community, utilizing natural supports and generic community services as much as possible
2. Staffs support persons receiving services in exercising their following rights without limitation:
    a. To be treated with respect and dignity as a human being;
    b. To have the same legal rights and responsibilities as any other person unless limited by law;
    c. To receive services regardless of gender, race, creed, marital status, national origin, disability or age;
    d. To be free of abuse, neglect or exploitation;
    e. To receive appropriate, quality services and supports in accordance with an individual support plan (ISP);
    f. To receive services and supports in the most integrated and least restrictive setting that is appropriate based on the service recipient's particular needs;
    g. To have access to DIDD rules, policies and procedures pertaining to services and supports;
    h. To have access to personal records and to have services, supports and personal records explained so that they are easily understood;
    i. To have personal records maintained confidentially;
    j. To own and have control over personal property, including personal funds;
    k. To have access to information and records pertaining to expenditures of funds for services provided;
    l. To have choices and make decisions;
    m. To have privacy;
    n. To receive mail that has not been opened by provider staff or others unless the person or family has requested assistance in opening and understanding the contents of incoming mail;
    o. To be able to associate, publicly or privately, with friends, family and others;
    p. To practice religion or faith of one's choosing;
    q. To be free from inappropriate use of physical or chemical restraint;
    r. To have access to transportation and environments used by the general public;
    s. To be fairly compensated for employment and;

t. To seek resolution of rights violations or quality of care issues without retaliation.

Policy Implementation Date:

AGENCY NAME

PROTECTION FROM AND PREVENTION OF HARM

Provider Manual Chapters 7 and 13, 13.2.f.8.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will protect the safety and welfare of the persons receiving services.

B. Objective

To develop procedures to help ensure that the safety and welfare of persons receiving services are protected.

C. Procedures

1. When an employee, student, or volunteer is implicated in allegations of physical or sexual abuse, that person will be placed on administrative leave or in a position that does not involve direct contact with or supervision of any person served or supervision of other staff that provide direct care, pending the completion of the investigation.
2. If the Director contends that the staff involved in physical or sexual abuse investigations should not be placed on administrative leave or reassigned, the provider may file a written request for an exception to this requirement with the DIDD Director of Investigations or designee.
   a) In such circumstances, the subject must be placed on administrative leave or reassigned pending approval or denial of the request.
   b) The Director shall address scheduling to accommodate this situation as needed and shall notify the DIDD Regional Office and the ISCs/CMs of persons receiving services as necessary if authorized waiver services will be affected.

1. Staff shall be instructed that the facts and circumstances being investigated are not to be discussed with anyone except the DIDD investigator or law enforcement officers and that if they do not adhere to this rule that they shall be subject to disciplinary actions.
2. Once the final investigative report is received the Director will:
   a) Within 15 days of the receipt of the report, notify the person investigated, in writing, of the outcome of the investigation (the report is not to be shared);
   b) Within 15 days of the receipt of the report, discuss the outcome of the investigation with the person(s) supported and invite the person's legal representative if any, to participate in this discussion. This meeting shall be documented;
   c) Address late reporting (if applicable); and,
   d) Respond to any incidental findings.
3. In instances where allegations are substantiated the director will submit a written Plan of Correction within 14 days of receipt of the Final Investigation Report and shall include the following information:
   a) Procedures implemented for protecting person(s) supported from risk of further abuse, neglect, or exploitation;
   b) What has or will be done to address late reporting (if applicable);

c) Verification that the substantiated perpetrator (s) was notified of the outcome of the investigation;
d) A statement of what, if any, disciplinary action occurred as a result of the findings of the investigation; and,
e) A response to any incidental findings contained in the investigation report.

4. The director will ensure that all corrective actions are completed.
5. Any person subject to this policy who retaliates against another person for his or her involvement as a reporter, witness, or in any other capacity related to incident management and/or investigations of abuse, neglect or exploitation shall be subject to disciplinary action, including possible termination. Such actions may also result in legal or other administrative measures as appropriate.
6. Falsification of incident reports, making false allegations, providing false information during an investigation, interfering with an investigation or withholding information during an investigation shall be subject to disciplinary action.
7. All incidents and investigations involving the agency shall be reviewed at least annually as a part of the self-assessment process.
8. Reportable incident forms, DIDD Final Investigation Reports and any Corrective Action Plans shall be kept confidential and shall be kept in a location separate from the record of the person supported.

Policy Implementation Date:

Provider Letterhead

Protection from Harm Statement

I [Name], certify and affirm that to the best of my knowledge and belief I have or have not (as applicable) had or received a finding of a substantiated case of abuse, neglect, mistreatment or exploitation against me. In order to verify this affirmation, I further release and authorize [Vendor_Name_Lower_Caps_as it_will_appear] and the Tennessee Department of Intellectual and Developmental Disabilities to have full and complete access to any and all current or prior personnel or investigative records as pertains to any substantiated allegations against me of abuse, neglect or mistreatment.

_____ _____

Signature Date

This form must be updated once per year.

AGENCY NAME

COMPLAINT RESOLUTION

Provider Manual-Chapter 13, 13.2.f.9.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____Agency Name_____ supports service recipient personally or through legal representatives and/or involved family members/friends to present complaints regarding the provision of services and be assured resolution to complaints and conflicts.

B. Objectives

1. To provide a procedure for persons receiving services, involved family members and/or their legal representatives to express complaints and conflicts/issues regarding the provision of care.
2. To describe complaint resolution procedures.

C. General Procedures for Complaint Resolution:

1. _____ staff will provide a copy of the complaint and conflict resolution policy to persons receiving services, involved family members and/or legal representative upon admission to the agency to ensure that information regarding complaint and conflict resolution is made available to them. A form indicating receipt of this policy must be maintained in the person's record.
2. All attempts will be made to resolve complaints at the most local level whenever possible.
3. Complaints or other issues may be presented verbally, informally, by phone, in written form, in person or mailed to _____Name/Company___(_____) to the attention of the Administrator.
4. The Administrator is _____Name/Company and can be reached at _____.
5. The complaint will be documented by the administrator and placed in the service recipient's record.
6. The administrator will respond to the issue within 2 working days following receipt of the complaint.
7. If necessary, a meeting will be held with all involved parties to discuss the issue and develop a plan for resolution.
8. All complaints will be resolved within 30 days from the receipt of the complaint unless outside involvement (i.e. DIDD) or mediation is required.
9. When the issue is resolved, the administrator will document the resolution in the service recipient's record as well as in the agency's internal complaints tracking system.
10. At any time, or if the issue is not brought to an acceptable resolution within a timely manner (no longer than 30 days), the provider or complainant/service recipient can request assistance from the DIDD Regional Office Complaint Resolution Coordinator to achieve resolution.
11. The administrator will track all complaints and the resolution of complaints in order to use the information during the agency's self-assessment process to utilize trends and patterns in order to initiate actions that will promote systemic improvements. The following will be tracked:
    - Date complaint received

- Name of complainant
- Contact information of complainant
- Name of service recipient
- ISC/CM and support agency names (as applicable)
- Description of complaint
- Resolution
- Date of resolution
- Date provider confirmed resolution with complainant

12. Retaliation by any employee of this agency against a complainant will result in disciplinary action and possible termination.
13. All Complaints Resolution System records will be made available to DIDD upon request.

Policy Implementation Date:

(The agency must develop an acknowledgement of receipt of the complaint policy)

AGENCY NAME

ASSURING STAFF COVERAGE AND SERVICE SCHEDULES

Provider Manual-Chapter 13, 13.2.f.10.

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ provides therapy services through the use of sufficiently qualified and trained staff who are available to provide the service in accordance with the schedule or the appointment time arranged.

B. Objectives

1. To ensure that services are provided to persons receiving services by sufficiently qualified and trained staff.
2. To ensure that services are provided in accordance with the schedule completed with the service recipient or the appointment time arranged.
3. To provide coverage for services when staff take periods of extended leave due to illness, resignation, or other unexpected events or circumstances.

C. Procedures

1. Agency staff will assess therapy staff's caseload to ensure they are capable of accepting more referrals.
2. Agency will track approved units and units of service provided.
3. Staff will schedule appointments in advance with the service recipient.
4. The service recipient and his/her family or staff will be notified as soon as possible if changes in the schedule must occur.
5. Staff will document reasons for missed visits.
6. Staff will notify the service recipient/home manager / family member as well as the manager of this therapy provider when there is more than one missed visit/month and/or there are other problems identified that may effect service provision provided as approved.
7. Agency will track and trend missed visits.
8. Agency and/or staff will work with the provider / family / ISC / case manger to promote services being provided as approved.
9. Agency/staff will promote continuity of care with service provision and if there are unexpected circumstances that occur, the service recipient, ISC and/or case manger will be given as much advance notice as possible.
10. The support coordinator or case manger will be notified with as much advance notice as possible any time that _____ anticipates the staff will take an extended leave for any reason.
11. Provision will be made for coverage of services during periods of extended leave using staff who are appropriately subcontracted and trained per DIDD requirements.
12. If agency needs to discontinue services for an unexpected reason, the ISC and/or case manager will be given a minimum of 60 day notice.
13. The agency will continue to provide the approved service until the service recipient has another agency to provide the service.

Policy Implementation Date:

AGENCY NAME

SUPERVISION PLAN FOR THERAPY ASSISTANTS

Provider Manual-Chapter 13, 13.2.f.11 and 13.9

A. Policy

_____ supervises therapy assistants according to the supervision plan.

B. Objectives

1. To establish a supervision plan to address how the agency accomplishes major supervisory functions.

C. Procedures

1. Supervisory staff will assure that therapy assistants understand their job duties and performance expectations;
2. Supervisory staff will assure that therapy assistants staff possess or acquire the knowledge and skills needed to complete job duties and meet performance expectations;
3. Supervisory staff will assure that they monitor staff performance to ensure performance issues are promptly identified and rectified by requiring or providing additional training, increased supervision, counseling and/or appropriate actions;
4. Supervisory staff will provide appropriate supervision to entry level staff in accordance with state licensure requirements and practice standards.
5. Ensuring that a minimum of one (1) scheduled onsite supervisory visit is conducted a minimum of every 60 days per person on the therapy assistant's caseload for Physical and Occupational Therapy Assistants.
6. Documentation of supervision will be maintained in the personnel files.
7. The agency administrator or designee will ensure that the act of supervision and the supervision plan will be evaluated for effectiveness and revisions completed as needed.

Policy Implementation Date:

AGENCY NAME

MAINTENANCE AND CONFIDENTIALITY OF MEDICAL RECORDS

Provider Manual-Chapters 10 and 13, 13.2.f.2. (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

A medical record shall be developed and maintained for each person admitted to the agency in a manner which will protect the privacy and rights of the person's health information.

B. Objectives

1. To maintain required documentation.
2. To note progress towards the Plan of Care goals and related Individual Support Plan (ISP) outcomes/actions.
3. To adhere to state and federal laws regarding maintenance of privacy of health information as required by the Health Insurance Portability and Accountability Act (HIPAA)
5. Establish procedures for HIPAA compliance.

C. Procedures

1. A medical record containing past and current findings in accordance with accepted professional standards will be maintained for every service recipient receiving professional support services.
2. The records will be stored in a manner that maintains the confidentiality of the information contained by preventing inappropriate access to the records.
3. Information contained in the records will be legible, clear, concise, complete and current.
4. Information will be factual.
5. Information will be organized in a systematic and chronological format.
6. Information will be written in ink or recorded in a typed/printed format.
7. Errors will be corrected by marking through the incorrect entry with a single line and recording the date and initials of the person correcting the entry.
8. Information documented in the service recipient records will be dated and authenticated by the signature and title of the person recording each entry.
9. Abbreviations will be spelled out in complete form followed with the abbreviation in parenthesis, when written the first time on a document.
10. The administrator/director will be responsible for records maintenance.
11. In addition to the physician's orders, assessment, and plan of care, the record shall contain the following components in compliance with standards set forth in the DIDD Provider Manual:
    - Appropriate identifying information
    - The service recipient or his/her designee's written consent for services.
    - Authorization for Release of Information
    - Name of referring agency
    - A diagnosis
    - All medications and treatments pertinent to services being provided
    - Plan of care/ recommendations based on assessment
    - Current ISP
    - Contact notes

- Monthly Progress notes
- Staff Instructions
- Training documentation as applicable
- Correspondence as applicable
- Discharge Summaries

12. Clinical notes shall be submitted no less than weekly to the administrator (if applicable).
13. Discharge summaries shall be written, dated and signed within seven (7) days of discharge.
14. All medical records, written, electronic, graphic or otherwise acceptable form, will be retained in their original or legally reproduced form for a minimum period of at least ten (10) plus one (1) years after the date of death or discharge for services requiring a Professional Support Services License and ten (10) years after the date of death or discharge for other clinical providers, after which such records may be destroyed.
15. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented in accordance with the agency's policies and procedures, and no record may be destroyed on an individual basis.
16. Even if the agency discontinues operations, records shall be maintained as mandated by this chapter and the Tennessee Medical Records Act (T.C.A.§§ 68-11-308). If a service recipient is transferred to another health care facility or agency, a copy of the medical record or an abstract shall accompany the service recipient, as needed, when the agency is directly involved in the transfer.
17. Medical records information shall be safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. The service recipient's or authorized person written consent shall be required for release of information when the release is not otherwise authorized by law.
18. For purposes of this rule, the requirements for signature or countersignature by a physician or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such a person of a unique code assigned exclusively to him or her, or by the entry of other unique or mechanical symbols, provided that such a person has adopted same as his or her signature in accordance with established protocol or rules.
19. Records shall be available for review by the Department of Intellectual and Developmental Disabilities and authorizing entities.

D. HIPAA Compliance

(Agency must develop HIPAA policy as well as Consent to Treat and Authorization to Release Information)

Policy Implementation Date:

AGENCY NAME

SELF-ASSESSMENT AND QUALITY ASSURANCE

Provider Manual-Chapter 13, 13.2.f.3 (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

A. Policy

_____ will engage in ongoing self-assessment and internal quality assurance and will participate in external quality assurance surveys.

B. Objectives
   1. To self-assess the quality of services provided.
   2. To identify and correct deficiencies which undermine the quality of services.
   3. To provide opportunities to evaluate the effectiveness of agency policies, and when necessary, make recommendations for changes needed to assure quality service provision.
   4. To track and trend internal data related to documentation and record keeping, incidents, investigations, complaints, etc. to determine individual or systemic changes needed to assure quality service provision.
   5. To identify training needs.
   6. To establish criteria to measure the effectiveness and efficiency of the services provided.
   7. To obtain feedback from the service recipient or service recipient's legal representative regarding satisfaction with services.

C. Procedures for External Quality Assurance
   1. Participate in the Department of Intellectual and Developmental (DIDD) Quality Assurance Surveys, Department of Health surveys (as applicable), or any focused agency reviews.
   2. Upon identifying issues, complete a Quality Improvement Plan as indicated following the Quality Assurance Survey or any investigations.
   3. Seek necessary technical assistance from DIDD or other external sources as needed to improve the quality of service provision.
   4. Participate in recommended technical assistance as indicated.
   5. Take part in mandated technical assistance as sanctioned, unless appealed.

D. Procedures for Internal Quality Assurance/Self-Assessment
   1. Complete an annual provider self-assessment consisting of ongoing review of the effectiveness of internal systems and service provision. The following components will be included in self-assessment activities prior to each Quality Assurance survey:
      i. Records management processes.
      ii. Trends in any incident reports completed or investigations involving clinical staff.
      iii. Review of external monitoring reports and identification of any trends.
      iv. Review of any personnel practices, including staff recruitment and hiring, staff training, and staff retention and turnover.
      v. Review of policies and procedures and any updates/revisions needed.

vi. Review of a sample of services provided, including persons supported discharged from services, to identify documentation issues and service effectiveness.
vii. Review of satisfaction survey processes and results.
viii. Steps taken or changes made in response to internal and external review findings, including any sanctions and/or recoupments imposed.
ix. Ways the information gained through self-assessment is communicated to other agency staff or those outside of the agency as appropriate.

2. Issues or areas of concern identified from the self assessment process will be utilized in Quality Improvement Planning:
    i. Areas of concern or need for improvement will be documented;
    ii. Documentation of solutions to the concerns are listed, discussed with the appropriate parties;
    iii. Feedback is sought from the service recipient or ongoing self-assessment process after the implementation of the solution to determine if satisfaction/improvement is achieved.

Policy Implementation Date:

(Agency must develop a satisfaction survey process)

TRANSPORTATION – Orientation and Mobility only as applicable

Provider Manual-Chapter 13, 13.2.f.4 (Page 13-5)

Note: For specific policy requirements refer to reference in Provider Manual. Policies need to be individualized per your agency.

Policy:
_____ will provide transportation for orientation and mobility training services as needed to fulfill services delegated in the service recipient's Plan of Care and Individual Support Plan (ISP). _____ will follow transportation procedures as set forth in the DIDD Provider Manual.

Objectives:

1. To assure a lack of transportation on the part of the service recipient or his/her residential/day/personal assistant agency, does not impede the ability to provide orientation and mobility services.
2. To promote safe provision of transportation services.

Procedures:

1. Certified Orientation and Mobility Specialist (COMS) vehicles used to transport persons receiving services must have operable seat belts;
2. COMS will ensure that persons receiving services are transported using seat belts in the proper manner;
3. COMS vehicles used to transport persons receiving services must be safe and have current tags and registration;
4. COMS will ensure mobility support needs applicable to transportation will be met in accordance with the ISP or staff instructions;
5. COMS will maintain a copy of the vehicle liability insurance certificate for vehicles used to transport persons receiving services;
6. Each vehicle used to transport persons receiving services must have the following first aid supplies:
    a. Assorted sizes of gauze pads and rolls of gauze;
    b. A triangular bandage;
    c. Assorted sizes of band-aids;
    d. Non-allergic tape;
    e. Plastic waste bags, preferably red biohazard bags;
    f. Disposable gloves;
    g. Hand cleaner such as soap and water, antiseptic pads or wipes, etc. for first aid kits to be used when the service recipient is away from home;
    h. A small flashlight with extra batteries;
    i. Disposable scissors and tweezers; and
    j. Liquid antibacterial soap.
7. COMS will not charge persons receiving services or persons receiving services' families for any of the cost incurred for routine maintenance, cleaning of vehicles or cellular telephone.

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Policy Implementation Date: